

1633

CERTIFICATE OF DEATH

Reg. Dist. No. ....

Item 9, Film 179 3-21-55 et

1. PLACE OF DEATH:

COUNTY **GARRETT** MD  
CITY (If outside corporate limits, write RURAL OR and give nearest town) **SWANTON MD** LENGTH OF STAY (in this place) **LIFE TIME**  
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE **MD** COUNTY **GARRETT**  
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN **SWANTON MD**  
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED:

(First) **MARY** (Middle) **CATHERINE** (Last) **BITTINGER**

4. DATE OF DEATH: **FEB. 28 1955**

5. SEX:

**FEMALE WHITE**

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): **WIDOWED**

8. DATE OF BIRTH:

**JAN.-17-1898**

9. AGE last birthday:

**77 7/16** yrs.

IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): **HOUSEWIFE**

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): **MD**

12. CITIZEN OF WHAT COUNTRY? **U.S.**

13. FATHER'S NAME:

**SIMEON KNOX**

14. MOTHER'S MAIDEN NAME:

**CAROLYN BROWN**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS:

**FRANK BITTINGER SWANTON MD.**

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

**422.1**  
Immediate cause

(a)

DUE TO

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b)

DUE TO

(c)

**Congestive heart failure**  
**Art. C. V. S.**

INTERVAL BETWEEN ONSET AND DEATH

**2 mos?**

**years**

II. OTHER SIGNIFICANT CONDITIONS:

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Not while work ☐ at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Jan. 55**, to **Feb. 28, 1955**, that I last saw the deceased alive on **Feb. 21, 1955**, and that death occurred at **3:30 P.M.**, from the causes and on the date stated above.

SIGNATURE

(DEGREE OR TITLE) ADDRESS

23. BURIAL, CREMATION REMOVAL (Specify):

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE RECD BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

**Thomas & Emily M. D. Oakland, Md.**  
**3/1/55**  
**BURIAL**  
**MARCH 3-1955**  
**BRENNEMAN CEMETERY NEAR SWANTON MD.**  
**3/8/1955**  
**Julia D. Downer**  
**Emory Boldin OAKLAND MD**

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 15 1955

BUREAU V. S.

22  
Capex

1634

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

01619

CERTIFICATE OF DEATH

Reg. Dist. No. 166

Item 12, Film G177 2-14-55 et

1. PLACE OF DEATH COUNTY <u>Garrett</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>West Virginia</u> COUNTY <u>Tucker</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Oakland</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Thomas</u> 85X-3	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Evans Rest Home</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (First) <u>John</u> (Middle) <u>BLACK</u> (Last) <u>BLACK</u>		4. DATE OF DEATH (Month) <u>Feb</u> (Day) <u>5</u> (Year) <u>1955</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>June 15, 1878</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Coal Miner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Coal</u>	9. AGE last birthday <u>76</u> yrs. If under 1 year: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
11. BIRTHPLACE (State or foreign country) <u>Futchberg, Austria</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Swartz</u>		14. MOTHER'S MAIDEN NAME <u>Mary Polinska</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If year, give war or dates of service)		16. SOCIAL SECURITY No. <u>232-09-6414</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Mary Black</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH <u>?</u> <u>year</u>
(a) <u>422.1 Immediate cause</u> <u>Congestive Heart Failure</u>			
(b) <u>Antecedent cause(s)</u> <u>Art. C. V. D.</u>			
(c) <u>Senility</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u>none</u>		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT (Specify) <u>none</u>		PLACE (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
HOMICIDE		INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			

22. I hereby certify that I attended the deceased from 12/21, 1954, to 2/1, 1955, that I last saw the deceased

alive on 2/1, 1955, and that death occurred at 10:35 P. m., from the causes and on the date stated above.

SIGNATURE Thomas D. Gushy M.D. ADDRESS Oakland, Md. DATE SIGNED 2/5/55

23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	DATE <u>Feb. 9, 1955</u>	NAME OF CEMETERY OR CREMATORY <u>Catholic Cemetery</u>	LOCATION (City, town, or county) <u>Thomas West Va.</u>
DATE RECD BY LOCAL REGISTRAR'S SIGNATURE <u>2/8/1955</u>		24. FUNERAL DIRECTOR <u>J. A. S. Duncan</u> ADDRESS <u>Thomas, W. Va.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED

FEB 10 1965

BUREAU V. S.

1635

## CERTIFICATE OF DEATH

Reg. Dist. No. 01621/62

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Garett</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Garett</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
<u>X</u> TOWN <u>Rural Grantsville</u>	<u>6-Days</u>	TOWN <u>Rural Grantsville</u>	<u>X</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	<u>1</u>

3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First)	(Middle)	(Month)	(Day)
<u>Henry</u>	<u>Willis</u>	<u>2</u>	<u>12</u>
(Type or Print)	<u>Brabson</u>	(Year)	<u>1955</u>
5. SEX:	6. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:
<u>Male</u>	<u>WIDOWED</u>	<u>2-5-1955</u>	<u>--</u> yrs.
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
<u>--</u>	<u>--</u>	<u>Rural Grantsville Md</u>	<u>U-S.A</u>
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<u>George. Harvey. Brabson</u>		<u>Lena ROSS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)	16. SOCIAL SECURITY No.:	17. INFORMANT & ADDRESS:	
<u>--</u>	<u>--</u>	<u>George Harvey Brabson. Grantsville Md</u>	

18. MEDICAL CERTIFICATION		Interval Between Onset And Death
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
<u>763.0</u>		<u>5 days</u>
Immediate cause (a) <u>Pneumonia</u>		
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) <u>DUE TO</u>		
(c)		

11. OTHER SIGNIFICANT CONDITIONS		20. AUTOPSY ?	
Conditions contributing to the death but not related to the disease or condition causing death.		Yes <input type="checkbox"/> No <input type="checkbox"/>	
19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION		
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)
			(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	HOW DID INJURY OCCUR ?	

22. I hereby certify that I attended the deceased from ..... 19..... to ..... 19....., that I last saw the deceased alive on ..... 19....., and that death occurred at 5:00 AM, from the causes and on the date stated above.

SIGNATURE		DATE SIGNED	
<u>Sally F. Whitehill, Jr. M.D.</u>		<u>2-12-55</u>	
(Degree or title)		ADDRESS	
<u>Grantsville, Md.</u>		<u>Grantsville Md</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>2-14-1955</u>	<u>Grantsville</u>	<u>Grantsville Md</u>
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>2-14-1955</u>	<u>Elmer Broadwater</u>	<u>Wm Winterberg</u>	<u>Grantsville Md</u>

4025336364

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

FEB 18 1935

RECEIVED

1636

## CERTIFICATE OF DEATH

Reg. Dist. No. 01622  
162

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Garett</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Garett</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural Grantsville</u>		LENGTH OF STAY (in this place) <u>6 Years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural Grantsville</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location) <u>/</u>			
3. NAME OF DECEASED:				4. DATE OF DEATH:			
(First) <u>Thomas</u>		(Middle) <u>Henry</u>		(Last) <u>Brennamon</u>		(Month) <u>2</u> (Day) <u>24</u> (Year) <u>1955</u>	
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Singel</u>		8. DATE OF BIRTH: <u>11-14-1873</u>	
9. AGE last birthday: <u>81</u> yrs.		10. BIRTHPLACE (State or foreign country): <u>Rural Bittinger Md</u>		11. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>			
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <u>Retired Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY: <u>Was Owner</u>			
13. FATHER'S NAME: <u>Joel Brennamon</u>				14. MOTHER'S MAIDEN NAME: <u>Catherine Bittinger</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.: <u>None</u>		17. INFORMANT & ADDRESS: <u>Frank Brennamon Bittinger Md</u>	
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						Interval Between Onset And Death	
<u>331X</u> Immediate cause (a) <u>Cerebral hemorrhage</u> Antecedent causes (s) (b) <u>arteriosclerosis, hypertension</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c)						<u>1 day</u>	
II. OTHER SIGNIFICANT CONDITIONS							
Conditions contributing to the death but not related to the disease or condition causing death. <u>coronary insufficiency</u>							
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21. ACCIDENT (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
SUICIDE		OF INJURY					
HOMICIDE							
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		HOW DID INJURY OCCUR?			
m.		10/16 54		2/23 55			
22. I hereby certify that I attended the deceased from <u>2/23</u> , 19 <u>55</u> , to <u>2/23</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>2/23</u> , 19 <u>55</u> , and that death occurred at <u>5:20 a.m.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Edith Broadwater</u>				DATE SIGNED <u>2/25/55</u>			
(Degree or title)				ADDRESS <u>Meversdale, Pa.</u>			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>2-27-1955</u>		<u>Bittinger Cemetary</u>		<u>Bittinger Garrett Co. Md</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>2/25/55</u>		<u>Edith Broadwater</u>		<u>Wm Winterberg</u>		<u>Grantsville Md</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

FEB 28 1955

RECEIVED



1637

## CERTIFICATE OF DEATH

Reg. Dist. No. 166

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY <b>GARRETT</b>	<b>MD.</b>		STATE <b>MD</b>	COUNTY <b>GARRETT.</b>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		
<b>X TOWN OAKLAND MD</b>			TOWN <b>OAKLAND MD.</b>		
HOSPITAL OR INSTITUTION OR STREET ADDRESS			STREET ADDRESS (If rural, give location)		
3. NAME OF DECEASED: (First) (Middle) (Last)			4. DATE OF DEATH: (Month) (Day) (Year)		
<b>CHARLES ELLWORTH DAWSON</b>			<b>FEB 24 1955</b>		
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR IF UNDER 24 HRS.
<b>MALE</b>	<b>WHITE</b>	<b>MARRIED</b>	<b>OCT. - 8 - 1879.</b>	<b>75</b> yrs.	Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):			11. BIRTHPLACE (State or foreign country):		
<b>RETIRED WOODMAN.</b>			<b>AMBOY W.VA.</b>		
10b. KIND OF BUSINESS OR INDUSTRY:			12. CITIZEN OF WHAT COUNTRY?		
			<b>U.S.</b>		
13. FATHER'S NAME:			14. MOTHER'S MAIDEN NAME:		
<b>ABRAHAM DAWSON.</b>			<b>CHARITY CALHOUN.</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			16. SOCIAL SECURITY No.:		
<b>No.</b>			<b>233-34-4040A.</b>		
17. INFORMANT & ADDRESS:					
			<b>CHESTER DAWSON MTLAKPARK MD</b>		

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

331X  
Immediate cause

(a) DUE TO

**Cerebral Hemorrhage**

INTERVAL BETWEEN ONSET AND DEATH

**3 days**

Antecedent cause(s)

(b) DUE TO

**Arteriosclerotic Hypertension****Several years**

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(c)

## II. OTHER SIGNIFICANT CONDITIONS:

Conditions contributing to the death but not related to the disease or condition causing death.

**Coronary Disease****Several years**

## 19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour)	INJURY OCCURRED	2. HOW DID INJURY OCCUR?			
OF INJURY	While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	<b>Feb. 24 1955 Feb. 23 1955</b>			
22. I hereby certify that I attended the deceased from <b>Feb. 22 1955</b> , to <b>Mar. 3 1955</b> , that I last saw the deceased alive on <b>Feb. 22 1955</b> , and that death occurred at <b>9:40 p.m.</b> , from the causes and on the date stated above.					
SIGNATURE		(DEGREE OR TITLE)	ADDRESS	DATE SIGNED	
<b>Charles E. Smith</b>		<b>MD</b>	<b>Jerres Alta WVa.</b>	<b>Mar 7 1955</b>	
23. BURIAL, CREMATION REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)	
<b>BURIAL</b>	<b>FEB-27-1955</b>	<b>GORTNER CEMETERY</b>	<b>NEAR OAKLAND</b>	<b>MD.</b>	
DATE REC'D BY LOCAL REG	REGISTRAR'S SIGNATURE	FUNERAL DIRECTOR		ADDRESS	
<b>2/27/1955</b>	<b>Julia K. Loman</b>	<b>Emory Baldwin</b>		<b>OAKLAND MD.</b>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAR 15 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01623

1638

CERTIFICATE OF DEATH

Reg. Dist. No. 161

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Garrett</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Garrett</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural, near Oakland</u>		LENGTH OF STAY (in this place) <u>Life time</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural, near Oakland, Md.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location) <u></u>			
3. NAME OF DECEASED: (First) <u>Leroy</u> (Middle) <u></u> (Last) <u>Friend</u>				4. DATE OF DEATH: (Month) <u>Feb.</u> (Day) <u>7</u> (Year) <u>1955</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>Apr. 22, 1878</u>	9. AGE last birthday: <u>77</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>near Oakland, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>John W. Friend</u>				14. MOTHER'S MAIDEN NAME: <u>Rachel Frye</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>No</u>		16. SOCIAL SECURITY No.: <u>214-16-2730</u>		17. INFORMANT & ADDRESS: <u>Mrs. Zelphia Friend, Star Rt. Oakland Md.</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>490X Acute Lobr Pneumonia (right)</u>						<u>1 day</u>	
Antecedent cause(s) (b) <u></u>							
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) <u></u>							
II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. <u>Hypertensive Heart Disease</u>							
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION:					
21. ACCIDENT (Specify) <u>SUICIDE</u>		PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Feb. 7, 1955</u> to <u>Feb. 7, 1955</u> , that I last saw the deceased alive on <u>Feb. 7, 1955</u> , and that death occurred at <u></u> m., from the causes and on the date stated above.							
SIGNATURE <u>Ralph Colandrella M.D.</u>		(DEGREE OR TITLE)		ADDRESS <u></u>		DATE SIGNED <u>Feb. 10-55</u>	
23. BURIAL, CREMATION REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>2/10/1955</u>		NAME OF CEMETERY OR CREMATORY <u>Glendale Cemetery</u>		LOCATION (City, town, or county) (State) <u>near Oakland, Md.</u>	
DATE RECD BY LOCAL REG. <u>2/9/1955</u>		REGISTRAR'S SIGNATURE <u>John Howan</u>		24. FUNERAL DIRECTOR <u>Emory Bolden</u>		ADDRESS <u>Oakland, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

FEB 17 1955

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 02697  
166

1639

1. PLACE OF DEATH- COUNTY <u>GARRETT</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>WEST VIRGINIA</u> COUNTY <u>PRESTON</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>OAKLAND</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>TERRA ALTA</u>	
TOWN <u>OAKLAND</u> LENGTH OF STAY (In this place) <u>1 day</u>		TOWN <u>TERRA ALTA</u> <u>85X-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>GARRETT COUNTY MEMORIAL HOSP.</u>		STREET ADDRESS (If rural, give location) <u>ROUTE # 3</u>	
3. NAME OF DECEASED (First) <u>LEONARD</u> (Middle) <u>H.</u> (Last) <u>GOFF</u>	4. DATE (Month) (Day) (Year) OF DEATH <u>FEBRUARY 17 1955</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>M</u>	8. DATE OF BIRTH <u>10-27-1874</u>
9. AGE last birthday <u>80 yrs.</u>		If under 1 year <u>3</u> Months <u>20</u> Days <u>20</u> Hours <u>15</u> Mins.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED CONDUCTOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>B&amp;O Railroad</u>	
11. BIRTHPLACE (State or foreign country) <u>WEST VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>GOFF, MARTIN VANBUREN</u>		14. MOTHER'S MAIDEN NAME <u>NEOMA ELLEN HARSH</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>705-09-7955</u>	
17. INFORMANT AND ADDRESS <u>LEONARD H. GOFF, ROUTE # 3 TERRA ALTA, W. VA.</u>			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
443X Immediate cause (a) <u>Cerebral - vascular accident</u>		<u>3 days</u>	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) <u>Hypertensive cardio-vascular disease</u>		<u>20 years</u>	
(c) <u>with grade IV cardiac failure</u>		<u>5 years</u>	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>auricular - fibrillation</u>		<u>30 yrs.</u>	
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT (Specify) <u>SUICIDE</u>		PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	
(CITY OR TOWN) (COUNTY) (STATE)			
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 1, 1950</u> , to <u>Feb 17, 1955</u> , that I last saw the deceased alive on <u>Feb 17, 1955</u> and that death occurred at <u>8:35 P.M.</u> , from the causes and on the date stated above.			
SIGNATURE <u>M. Dorcas Clair Harley, M.D.</u>		ADDRESS <u>Terra Alta, W. Va.</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>Feb. 20, 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Weaver-Rhodes Cemetery</u>		LOCATION (City, town, or county) <u>near Boredman, W. Va.</u>	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <u>Julia Rowan</u>		24. FUNERAL DIRECTOR <u>R. H. Nelson</u>	
REG. NO. <u>55</u>		ADDRESS <u>Terra Alta, W. Va.</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAR 15 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1640

## CERTIFICATE OF DEATH

Reg. Dist. No.

01624

762

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <b>Garrett</b>	MARYLAND	STATE <b>Md.</b>	COUNTY <b>Garrett</b>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <b>X</b> TOWN <b>Bloomington</b>	LENGTH OF STAY (in this place) <b>50 Yrs</b>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Bloomington</b>	<b>X</b>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Unincorporated</b>		STREET ADDRESS (If rural give location) <b>/</b>	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) <b>Benton</b>	(Middle) <b>Harshbarger</b>	OF DEATH: <b>Feb. 19 19 55</b>	
5. SEX: <b>Male</b>	6. COLOR OR RACE: <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Married</b>	8. DATE OF BIRTH: <b>Jan. 15, 1869</b>
9. AGE last birthday <b>86</b> yrs.		IF UNDER 1 YEAR: Months Days Hours Mln.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>Miner</b>		10B. KIND OF BUSINESS OR INDUSTRY: <b>Coal Mine</b>	
11. BIRTHPLACE (State or foreign country): <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME: <b>Samuel Harshbarger</b>		14. MOTHER'S MAIDEN NAME: <b>Amy J. Yaste</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <b>No</b> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>00</b>	
17. INFORMANT & ADDRESS: <b>Mrs. Benton Harshbarger, Bloomington,</b>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
420.0 IMMEDIATE CAUSE (A) <b>Chronic heart failure</b>		4 yrs	
ANTECEDENT CAUSE (S) (B) <b>Hypertensive arteriosclerotic heart disease</b>		30 yrs	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. HOW DID INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from <b>1946</b> , to <b>Feb 19, 1955</b> , that I last saw the deceased alive on <b>Feb 19, 1955</b> , and that death occurred at <b>5 P.</b> M, from the causes and on the date stated above.			
SIGNATURE <b>James S. Walther Jr.</b>		DATE SIGNED <b>2-21-55</b>	
ADDRESS <b>Providence W. Va</b>		M. D.	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		24. FUNERAL DIRECTOR <b>E.S. Boal, Westernport, Md.</b>	
DATE REC'D BY LOCAL REGISTRAR <b>2-21-55</b>		REGISTRAR'S SIGNATURE <b>Emory Patterson</b>	

RECEIVED

FEB 24 1955

BUREAU V. 3



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1641

01625

166

1. PLACE OF DEATH- COUNTY GARRETT MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE GARRETT COUNTY	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN OAKLAND		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN OAKLAND	
HOSPITAL OR INSTITUTION OR STREET ADDRESS GARRETT COUNTY MEMORIAL		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) GAY	(Middle) WILLARD	(Last) HAYDEN
5. SEX	MALE	6. COLOR OR RACE	WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	WIDOWER	8. DATE OF BIRTH	JUNE 5, 1887
9. AGE last birthday	67 yrs.	10. KIND OF BUSINESS OR INDUSTRY	B & O
11. BIRTHPLACE (State or foreign country)	OAKLAND, MARYLAND	12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME	JAMES HAYDEN	14. MOTHER'S MAIDEN NAME	LATISHA SAVAGE
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY No. (If yes, give war or dates of service)	17. INFORMANT AND ADDRESS
		1705-05-1766	MT. LAKE PARK, WILIARD HAYDEN, MARYLAND

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331X

Immediate cause

(a)

Cerebral Hemorrhage

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

Hypertension

(c)

Arterio Sclerosis

INTERVAL BETWEEN ONSET AND DEATH

2 wks

## 11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☒

## 21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 1945, to 2-13-1955, that I last saw the deceased

alive on 2/12, 1955, and that death occurred at 8:05 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Dr. E. I. Bauman

Oakland Md

2/13/55

## 23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

BURIAL

FEB 15, 1955

OAKLAND

OAKLAND

MD.

DATE REC'D BY LOCAL

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

2/14/55

Julia J. J. J.

Emory Bolden

OAKLAND, MD.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

BUREAU V. S.

FEB 17 1955

RECEIVED

02699

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1642

## CERTIFICATE OF DEATH

Reg. Dist. No.....

## 1. PLACE OF DEATH:

COUNTY

GARRETT

MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town),  
TOWN

CRELLIN MD.

HOSPITAL OR  
INSTITUTION OR  
STREET ADDRESS

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE

MD

COUNTY

GARRETT.

CITY (If outside corporate limits, write RURAL and give nearest town)  
OR  
TOWN

CRELLIN

MD. X

STREET  
ADDRESS

(If rural, give location)

3. NAME OF  
DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

KAREN

THERESE

KENDALL

4. DATE  
OF  
DEATH:

(Month)

(Day)

(Year)

FEB.

21

1953

## 5. SEX:

6. COLOR OR  
RACE:7. SINGLE, MARRIED,  
WIDOWED, DIVORCED,  
(Specify):

## 8. DATE OF BIRTH:

## 9. AGE last birthday:

IF UNDER 1 YEAR IF UNDER 24 HRS.

FEMALE

WHITE

FEB-28-1954

yrs.

11

21

Min.

10a. USUAL OCCUPATION (Give kind of  
work done during most of working life,  
even if retired):10b. KIND OF BUSINESS OR  
INDUSTRY:

## 11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT  
COUNTRY?

OAKLAND MD

U.S.

## 13. FATHER'S NAME:

SAMUEL

KENDALL

## 14. MOTHER'S MAIDEN NAME:

MARY ALICE VAN HOOSE

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unk.) (If Yes, give war or dates of  
service)

## 16. SOCIAL SECURITY No.:

## 17. INFORMANT &amp; ADDRESS:

SAMUEL KENDALL

CRELLIN MD

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause

(a).....

DUE TO

Antecedent cause(s)

Diseases or conditions, if any,  
giving rise to the above cause  
stating underlying cause last

(b).....

DUE TO

(c).....

INTERVAL BETWEEN  
ONSET AND DEATH

3 days

## II. OTHER SIGNIFICANT CONDITIONS:

Conditions contributing to the death but not  
related to the disease or condition causing death.

## 19a. DATE OF OPERATION:

## 19b. MAJOR FINDINGS OF OPERATION:

## 20. AUTOPSY?

Yes ☐ No ☒21. ACCIDENT  
SUICIDE  
HOMICIDE

(Specify)

PLACE (Home, farm, factory, street,  
OF  
office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)  
OF  
INJURYINJURY OCCURRED  
While at Not while  
work ☐ at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased  
alive on....., 19....., and that death occurred at....., from the causes and on the date stated above.

SIGNATURE

(DEGREE OR TITLE) ADDRESS

DATE SIGNED

23. BURIAL, CREMATION  
REMOVAL (Specify):

## DATE THEREOF

## NAME OF CEMETERY OR CREMATORY

## LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL  
REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

FEB-23-1953 OAKLAND CEMETERY OAKLAND MD

Emory Bolden OAKLAND MD

2024242383

MARGIN RESERVED FOR BINDING

VS. A15 8-51

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 15 1955

BUREAU V. S.

1643

## CERTIFICATE OF DEATH

Reg. Dist. No. 167

## 1. PLACE OF DEATH:

COUNTY

GARRETT.

MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town)

X TOWN RURAL OAKLAND MD.

LENGTH OF STAY (in this place)

2 WEEKS.

HOSPITAL OR INSTITUTION OR STREET ADDRESS

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE MD

COUNTY GARRETT.

CITY (If outside corporate limits, write RURAL and give nearest town)

OR TOWN RURAL OAKLAND MD. X

STREET ADDRESS (If rural, give location)

## 3. NAME OF DECEASED:

(First)

(Middle)

(Last)

HATTIE

VICTORIA

LLOYD.

4. DATE OF DEATH:

(Month)

(Day)

(Year)

FEB - 19 1955.

## 5. SEX:

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

## 8. DATE OF BIRTH:

9. AGE last birthday:

IF UNDER 1 YEAR IF UNDER 24 HRS.

FEMALE WHITE

MARRIED JUNE-14-1886

68 yrs.

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY?

COLUMBIA FURNACE. VA.

U.S.

## 13. FATHER'S NAME:

JAMES MINNICK.

## 14. MOTHER'S MAIDEN NAME:

SARAH MILLER.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT &amp; ADDRESS:

FRANK LLOYD. GORMANIA W. VA.

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

420.0 Immediate cause

(a)

DUE TO

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b)

DUE TO

(c)

Coronary Heart Disease  
Arterio Sclerotic Heart Disease

INTERVAL BETWEEN ONSET AND DEATH

3 years

8 years

## II. OTHER SIGNIFICANT CONDITIONS:

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION:

## 19b. MAJOR FINDINGS OF OPERATION:

## 20. AUTOPSY?

Yes ☐ No ☐

## 21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Not while work ☐ at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8:30 PM 1949, to 1:30 PM, 1955, that I last saw the deceased alive on 1:30 PM, 1955, and that death occurred at 8:15 A.M., from the causes and on the date stated above.

SIGNATURE

(DEGREE OR TITLE) ADDRESS

DATE SIGNED

## 23. BURIAL, CREMATION REMOVAL (Specify):

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE RECD BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

2-23-55

Blmer C. Sheffer

Emory Bolden OAKLAND MD.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 3 1955

BUREAU V. S.

1644  
CERTIFICATE OF DEATH

Reg. Dist. No. ....

Items 2 9 Filmcl 79 3-22-55 et

## 1. PLACE OF DEATH:

COUNTY GARRETT

MD

MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town)

TOWN OAKLAND

MD

LENGTH OF STAY (in this place)

HOSPITAL OR INSTITUTION OR STREET ADDRESS

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE MD

COUNTY

GARRETT.

CITY (If outside corporate limits, write RURAL and give nearest town)

TOWN OAKLAND

MD.

STREET ADDRESS

(If rural, give location)

## 3. NAME OF DECEASED:

(First)

(Middle)

(Last)

JOHN

ROMANUS

MURPHY

## 5. SEX:

MALE

WHITE

RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

MARRIED OCT. - 9 - 1885

## 8. DATE OF BIRTH:

9. AGE last birthday:

IF UNDER 1 YEAR

IF UNDER 24 HRS.

69 6/8/1 yrs.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

RETIRED TELEGRAPHER.

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

DEER PARK MD.

12. CITIZEN OF WHAT COUNTRY?

U.S.

## 13. FATHER'S NAME:

JOSEPH

MURPHY.

## 14. MOTHER'S MAIDEN NAME:

MARY

CONNER.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or nkn.) (If Yes, give war or dates of service)

3NO.

16. SOCIAL SECURITY No.:

705-05-824

17. INFORMANT &amp; ADDRESS:

ESTELLE MURPHY. OAKLAND

MD.

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause

(a)

DUE TO

Antecedent cause(s)

(h)

DUE TO

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(c)

INTERVAL BETWEEN ONSET AND DEATH

4 years

8 years

## II. OTHER SIGNIFICANT CONDITIONS:

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION:

## 20. AUTOPSY?

Yes ☐ No ☐

## 21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office hldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4 Jan., 1946 to 24 Feb., 1955, that I last saw the deceased alive on 23 Feb., 1955, and that death occurred at 11:30 A.M., from the causes and on the date stated above.

SIGNATURE

(DEGREE OR TITLE) ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify):

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

2/28/1955

Julia A. Towan

Emory Bolden

OAKLAND

MD.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 15 1955

BUREAU V. S.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02702

1645

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

Item 7, FilmG179 3-23-55 et

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Garrett</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>Gar</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>TOWN</u> <u>Sarmama-Rural</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) <u>TOWN</u> <u>Sarmama</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>(Backbow Mountain)</u>		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) <u>TONY</u>	(Middle) <u>JOHN</u>	(Last) <u>REPETSKY</u>	(Month) <u>Feb</u> (Day) <u>10</u> (Year) <u>1955</u>
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>Nov. 1878</u>
9. AGE last birthday: <u>76</u> yrs.		10. BIRTHPLACE (State or foreign country): <u>LITHUANIA</u>	
11a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <u>MINER</u>		11b. KIND OF BUSINESS OR INDUSTRY: <u>COAL MINES</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME: <u>STANLEY REPETSKY</u>	
14. MOTHER'S MAIDEN NAME: <u>UNKNOWN</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No.</u> (If Yes, give war or dates of service)	
16. SOCIAL SECURITY No.: <u>232-09-0475</u>		17. INFORMANT & ADDRESS: <u>HELEN REPETSKY</u>	
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			Interval Between Onset And Death <u>1 week</u>
Immediate cause (a) <u>congestive heart failure</u>			
Antecedent causes (s) (b) <u>art. C.V. D.</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death: <u>chronic Bronchitis</u>			
19a. DATE OF OPERATION: <u>none</u>		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT (Specify) <u>none</u>		22. I hereby certify that I attended the deceased from <u>7 Apr.</u> , 19 <u>55</u> , to <u>8 Feb.</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>8 Feb.</u> , 19 <u>55</u> , and that death occurred at <u>3 AM</u> , from the causes and on the date stated above.	
SIGNED <u>Thomas J. Early M.D.</u>		SIGNED <u>Oakland Md.</u> <u>2/10/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		DATE THEREOF <u>2/12/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Catholic</u>		LOCATION (City, town, or county) (State) <u>Thomas, N.Y.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>2/12/55</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>	
24. FUNERAL DIRECTOR <u>[Signature]</u>		ADDRESS <u>[Address]</u>	

BUREAU V. S.

MAR 15 1955

RECEIVED

1646

## CERTIFICATE OF DEATH

Reg. Dist. No. 166

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Garret</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>Garr</u>
CITY (If outside corporate limits, write OR and give nearest town) <u>Cahland</u>	RURAL LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cahland - Rural</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Evans Nursing Home</u>		STREET ADDRESS (If rural give location) <u>X</u>	
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) <u>MARY</u>	(Middle) <u>S</u>	(Last) <u>SHAFFER</u>	(Month) <u>Feb</u> (Day) <u>5</u> (Year) <u>1955</u>
5. SEX: <u>FEMALE</u>	5. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH: <u>MAR 19, 1864</u>
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY:	9. AGE last birthday: <u>90</u> yrs. If UNDER 1 YEAR: Months Days Hours Min.
11. BIRTHPLACE (State or foreign country): <u>AURORA WVA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>DAVID WOTRING</u>		14. MOTHER'S MAIDEN NAME: <u>LOUISE WAITZ</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:	
17. INFORMANT & ADDRESS: <u>DAVID SHAFFER</u>			

18. MEDICAL CERTIFICATION		Interval Between Onset And Death
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Congestive heart failure</u>		<u>not?</u>
Antecedent causes (s) (b) <u>A.H.C.U.D.</u>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c)		

11. OTHER SIGNIFICANT CONDITIONS		
Conditions contributing to the death but not related to the disease or condition causing death. <u>Senility</u>		
19a. DATE OF OPERATION: <u>none</u>	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) <u>none</u>	PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 19 Nov. 1947, to 5 Feb. 1955, that I last saw the deceased alive on 1 Feb. 1955, and that death occurred at 10:20 AM from the causes and on the date stated above.

SIGNATURE (Degree or title) Thomas J. Gush M.D. ADDRESS Cahland Md DATE SIGNED 5 Feb 55

23. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	DATE THEREOF <u>FEB 8, 55</u>	NAME OF CEMETERY OR CREMATORY <u>CARMEI CEMETERY</u>	LOCATION (City, town, or county) (State) <u>AURORA, PRESTON, WVA.</u>
DATE REC'D BY LOCAL REGISTRAR <u>7/7/55</u>	REGISTRAR'S SIGNATURE <u>Julian J. Gayer</u>	24. FUNERAL DIRECTOR <u>Wayne C. Spiggle</u>	ADDRESS <u>Davis, W.Va.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
FEB 10 1935  
BUREAU V. S.

1647

## CERTIFICATE OF DEATH

Reg. Dist. No. 016286

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Garrett</u>	MARYLAND	STATE <u>West Virginia</u>	COUNTY <u>Monongalia</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
<u>X</u> TOWN <u>Oakland</u>	<u>2 yrs.</u>	TOWN <u>Morgantown</u>	<u>85 X-3</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Cuppett Nursing Home</u>		STREET ADDRESS (If rural, give location) <u>Communtzie Apt. High Street</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE OF DEATH: (Month) (Day) (Year)	
(Type or Print) <u>Chester L. Walls</u>		<u>Feb. 7, 1955</u>	
5. SEX: <u>Male</u>	5. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH: <u>1/22/1867</u>
9. AGE last birthday: <u>88</u> yrs.		IF UNDER 1 YEAR   IF UNDER 24 HRS.	
		Months   Days   Hours   Min.	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired. <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Own Farm</u>	11. BIRTHPLACE (State or foreign country): <u>West Virginia</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME: <u>A. F. Walls</u>	
14. MOTHER'S MAIDEN NAME: <u>Elizabeth Adams</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)	
16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <u>Mrs. Bess Cuppett Oakland, Md.</u>	

## 18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	Interval Between Onset And Death
<u>422.1</u> Immediate cause (a) <u>Cerebrovascular Accident</u> DUE TO <u>Ant. C. V. D.</u> (b) <u>Ant. C. V. D.</u> DUE TO (c)	<u>7 days?</u> <u>years</u>
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.	

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Senility</u>	
19a. DATE OF OPERATION: <u>none</u>	19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify) <u>none</u>	PLACE (Home, farm, factory, street, office bldg., etc.)
SUICIDE	(CITY OR TOWN) (COUNTY) (STATE)
HOMICIDE	
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While at Work <input type="checkbox"/>
HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 10/8/53, 1953, to 2/7/55, 1955, that I last saw the deceased alive on 2/7, 1955, and that death occurred at 10:15 P M from the causes and on the date stated above.

(SIGNATURE) <u>Thomas L. Lushy M.D.</u>	(Degree or title)	ADDRESS <u>Oakland, Md.</u>	DATE SIGNED <u>2/8/55</u>
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>2/10/1955</u>	NAME OF CEMETERY OR CREMATORY <u>Fairview Cemetery</u>	LOCATION (City, town, or county) (State) <u>Pisgah, Preston Co., W. Va.</u>
DATE REC'D BY LOCAL REGISTRAR <u>2/8/55</u>	REGISTRAR'S SIGNATURE <u>Julia A. Rozz...</u>	24. FUNERAL DIRECTOR <u>Herbert C. Leighton</u>	ADDRESS <u>Oakland, Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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FEB 17 1935

BUREAU V. S.

MARYLAND

1648

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STATE DEPARTMENT OF HEALTH

## CERTIFICATE OF DEATH

Reg. Dist. No. 172

1. PLACE OF DEATH COUNTY <b>GARRETT</b> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <b>MARYLAND</b> COUNTY <b>GARRETT</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>KITZMILLER</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>KITZMILLER</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>W. MAIN ST.</b>		STREET ADDRESS (If rural, give location) <b>W. MAIN STREET</b>	
3. NAME OF DECEASED (Type or Print) <b>ORA MAUD WEICHT</b>		4. DATE OF DEATH (Month) <b>FEB.</b> (Day) <b>15,</b> (Year) <b>1955</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>JAN. 7, 1882</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	9. AGE last birthday <b>73</b> yrs.
11. BIRTHPLACE (State or foreign country) <b>Hampshire Co., W.Va.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13. FATHER'S NAME <b>DAVID WINFIELD ARNOLD</b>		14. MOTHER'S MAIDEN NAME <b>MOLLY EVERETT</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) <b>NO</b>		16. SOCIAL SECURITY No. <b>NONE</b>	
17. INFORMANT AND ADDRESS <b>RONALD D. WEICHT, HAGERSTOWN, MD.</b>			

  

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
(a) Immediate cause <b>Acute Myocardial Infarction</b>		<b>3 days</b>
(b) Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		<b>5 years</b>
(c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <b>Jan</b> , 1950, to <b>Feb. 15</b> , 1955, that I last saw the deceased alive on <b>Feb. 15</b> , 1955, and that death occurred at <b>1:45 P.</b> m., from the causes and on the date stated above.		
SIGNATURE <b>Ralph Calabrella M.D.</b>		DATE SIGNED <b>Feb. 16, 55</b>
23. BURIAL, CREMATION OR OTHER DISPOSAL (Specify) <b>BURIAL</b>	DATE <b>2/17/55</b>	NAME OF CEMETERY OR CREMATORY <b>I.O.O.F. CEMETERY</b>
DATE REC'D BY LOCAL REG. <b>2/16/55</b>	REGISTRAR'S SIGNATURE <b>C. W. Barwick</b>	24. FUNERAL DIRECTOR <b>OTHA F. SHARPLESS, BLAINE, W.Va.</b>

BUREAU V. S.

FEB 21 1955

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 016301

1649

## CERTIFICATE OF DEATH

Reg. Dist. No. 166

Item 9, film 177 2-15-55 et

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Garrett</u>		MARYLAND		STATE <u>MD</u> COUNTY <u>GARRETT</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Oakland</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>OAKLAND</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
<u>BESSIE HADDON ZAHN</u>				<u>Feb 3 1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday: yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>FEMALE</u>	<u>WHITE</u>	<u>WIDOWED</u>	<u>FEB-18-1869</u>	<u>85 8/6</u>	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY:		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
11. BIRTHPLACE (State or foreign country): <u>UNIONTOWN PA.</u>							
13. FATHER'S NAME: <u>JOHN HADDON.</u>				14. MOTHER'S MAIDEN NAME: <u>ELLEN HOOK.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.:			
				17. INFORMANT & ADDRESS: <u>1228. BEESON AVE. MISS VIRGINIA MARSHALL UNIONTOWN. PA.</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
422.1 Immediate cause (a) <u>Art. C. V. D &amp; Heart Failure</u>						<u>years</u>	
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last						DUE TO	
(c)							
II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death <u>Senility &amp; Arthritis</u>							
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION:			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
INJURY		INJURY OCCURRED While at Not while work work		HOW DID INJURY OCCUR?			
TIME (Month) (Day) (Year) (Hour)		OF INJURY					
22. I hereby certify that I attended the deceased from <u>30 Nov 47</u> , 19 <u>47</u> , to <u>2/3</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12/23</u> , 19 <u>54</u> , and that death occurred at.....m., from the causes and on the date stated above.							
SIGNATURE <u>Thomas J. Early M.D.</u>				(DEGREE OR TITLE) <u>Oakland, Md</u>		DATE SIGNED <u>2/4/55</u>	
23. BURIAL, CREMATION REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>FEB-5-1955</u>		<u>OAKLAND CEMETERY</u>		<u>OAKLAND MD.</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>2/5/55</u>		<u>Julius J. Brown</u>		<u>Emory Bolden</u>		<u>OAKLAND MD.</u>	

BUREAU V. S.

FEB 10 1935

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